STATE OF WASHINGTON
DEPARTMENT OF LABOR AND INDUSTRIES
PO Box 44261 Olympia, Washington 98504-4261

BILLING INSTRUCTIONS – STATE FUND CLAIMS
HCFA – 1500 BILL FORM
F245-127-000

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Ambulatory Surgery Center,
Anesthesiologist, Chiropractor, CRNA, Hospital ER/Professional Services, Laboratories, Naturopath, Osteopathic Physician, Outpatient Pain Management Program, Panel Examiner, Pathologist, Physical Therapist, Physician, Physician Assistant, Physician Clinic, Podiatric Physician, Psychologist, Radiologist

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BILLING INSTRUCTIONS

Labor and Industries (L&I) processes all provider bills using an automated system called the Medical Information Payment System (MIPS). In order to process your bills promptly and accurately, they must be completed as described in these instructions. Improperly submitted bills will be denied or returned for completion or correction.

For billing requirements for Self-Insurers and their service companies contact the Self-Insurance section at 360-902-6901.

L&I Provider Account Number Required:
If you do not have an L&I provider account number, please call Provider Accounts at (360) 902-5140 to request a provider application form. This form and several other of the most frequently requested forms can also be downloaded from our website at www.wa.gov/lni/forms. You may also request additional forms from your local field service location; a listing of these locations is contained on the last page of this billing instruction booklet. Submit your bill after you receive your L&I provider account number or for your first submission only, attach it to your completed application.

Billing on Paper Forms:
Submit charges on the "HCFA-1500" bill form (F245-127-000).

Mail HCFA-1500 bill forms to:

Department of Labor and Industries
PO Box 44269
Olympia, Washington 98504-4269

Bill Forms – Where and How to get them:
Bills must be submitted on ORIGINAL (not photocopied) HCFA-1500 bill forms. Bill forms are furnished free of charge to providers. To order forms, contact the Labor and Industries Field Service Location office nearest you; a listing of these locations is contained on the last page of this billing instruction booklet. Providers outside Washington State may contact Provider Accounts at (360) 902-5140 or the Provider Hotline at 1-800-848-0811. When ordering, give your full name, address, L&I provider account number, quantity needed for six months, and the L&I form number (FXXX-XXX-000 for single sheet, or FXXX-XXX-111 for continuous pinfeed).

Billing Electronically:
Please contact the Electronic Billing Unit at (360) 902-6511 or (360) 902-6512 if you are able to and are interested in submitting bills electronically.

When to Submit Bills:
You should submit bills at the time the first required report is written. Billings should then be sent every 30 days thereafter until the conclusion of services. A separate bill form must be completed for each claim number but each bill form may contain more than one date of service. All dates of service must be billed separately.

When payments are made:
The department issues warrants to providers every two-weeks for bills that have processed to final status. An L&I Remittance Advice is also provided to you at two-week intervals. Remittance Advices provide a report of the status of your bill(s) that have been processed, or are in process. When contacting the department with a billing problem, please have the appropriate copy of the Remittance Advice in hand before calling. Many

billing questions can be answered by reading the Remittance Advice.

Credit Balance Bills (CRE) – The bills will be held in abeyance until the credit balance is satisfied. These bills should be treated as "Bills in Process". Do not post or rebill these bills as long as they appear in this section. **This is money owed to the department.** Payment(s) to clear your credit balance should be mailed to:

Department of Labor and Industries
Cashier's Office
PO Box 44835
Olympia WA 98504-4835

Limits on Bill Processing:
Bills must be received within one year of the date of service to be considered for payment. Rebills must be submitted for services denied if a claim was closed and subsequently reopened or if a claim or diagnosis was rejected and subsequently allowed. In these instances, the rebill must be received within one year of the date the final order is issued, which subsequently reopens or allows the claim or diagnosis.

For Help:
If you have questions about "PAID BILLS", "DENIED BILLS" or "ADJUSTMENT BILLS", please call the Provider Hotline at 1-800-848-0811. **Please have a copy of the appropriate Remittance Advice in hand before calling.**

If you have questions about "BILLS IN PROCESS", please call the automated Claim Information line at 1-800-831-5227, for up to the minute bill status. From that line, you may choose the "zero" option to be connected to the Bill Payment Unit.

If you have general questions about an injured workers claim or time-loss payment, please call the automated Claims Information line at 1-800-831-5227. More than one claim number can be accessed per phone call and any 'wait time' is minimal.

If an injured worker has general questions about their claim, please give them the 1-800-831-5227 number or the 1-800-LISTENS (547-8367) number for assistance with claim problems including time-loss. If they have bill questions, you may give them the Provider Hotline number 1-800-848-0811.

Note: A completed Report of Accident does not constitute a bill. Bills must be submitted separately to be considered for payment.

REPORTING REQUIREMENTS

DO NOT ATTACH REPORTS TO THE BILLS

The following required **reports** and **documentation** must be sent separately from your bills in order for them to be routed to the proper department and placed in the proper file:

a. Consultation reports
b. Laboratory and X-ray reports
c. Special reports and/or narratives to support level of office visit or procedure
d. Operative reports/anesthesia records
e. Periodic office notes
f. Periodic chart notes

The injured workers' name and claim number must be placed in the upper right corner of <u>each page</u> on any correspondence or report.

The cost invoices for supplies furnished are not routinely required to be mailed to the department, but may be requested in specific cases.

See WAC 296-20 for additional requirements and report definitions.

Send all reports and documentation for State Fund claims to:

Department of Labor and Industries
PO Box 44291
Olympia WA 98504-4291

PROVIDER SPECIFIC INSTRUCTIONS

Ambulatory Surgery Center

Type of service:

Use type of service code "3" with CPT® and HCPCS codes.

Modifiers:

May use SG modifier with each line item.
CPT® modifers: 50, 51, 52, 59, 73, 74, 76, 77, 99

Ambulatory Surgery Centers (ASCs) must have a valid ASC provider account with L&I to be paid for services.

ASCs will not be paid for services, which are not covered by the department. Non-covered codes are listed in the ASC section of the *Medical Aid Rules and Fee Schedules*.

ASCs should bill for implants on a separate line. The following HCPCS implant codes are covered by the department in an ASC: L8500 through L8699. Intraocular lenses (i.e. V2630, V2631, V2632) are the exception. These are included in the facility payment and will not be paid separately. ASCs will be paid the acquisition cost for all implants.

For injection procedures which require the use of radiographic localization and guidance, ASCs must bill for the technical component of the radiological CPT® code (e.g. 76005 – TC).

For more information, please refer to WAC 296-23B, Provider Bulletin 01-12, and to the ASC sections of the *Medical Aid Rules and Fee Schedules*. Information can be viewed and downloaded from www.lni.wa.gov/hsa.

Anesthesiologist

Type of Service:

Use Type of Service code "3" with CPT, HCPCS and Local Codes

Modifiers

CPT Modifiers: -23 & -99
HCPCS Modifier: -AA, -QK and -QY

Anesthesiologists must have valid individual L&I provider account numbers to be paid for services. The department does not cover anesthesia assistant services.

Anesthesia is not payable for procedures that are not covered by the department. Non-covered codes are listed in Appendix E of the "Washington RBRVS Payment Policies" section in the current Medical Aid Rules and Fee Schedules.

Anesthesia services paid with base and time units must be billed using CPT anesthesia codes 00100 through 01999 or ASA codes 01951 and 01952. Refer to "Anesthesia Services Paid with Base and Time Units" in the

Anesthesia Payment Policies section in the current Medical Aid Rules and Fee Schedules.

Effective for dates of service on or after July 1, 2000, anesthesia reimbursement will be calculated using 15-minute time units. This change does not affect how providers bill for services, or how the department calculates payments. Providers should continue to bill for services in one-minute time units.

For more information, please refer to the "Anesthesia Payment Calculation" section of the current Medical Aid Rules and Fee Schedules, and to the current PB 00-05. Provider Bulletins can be viewed/downloaded from www.wa.gov/lni/hsa/hsa_pbs.htm.

Chiropractor

Type of Service:

Use Type of Service code "C" with CPT, HCPCS and Local Codes

The department will not pay chiropractic physicians for additional codes that are not specifically allowed. Refer to the appendices in the "Washington RBRVS Payment Policies" section in the current Medical Aid Rules and Fee Schedules.

Chiropractic Care Visit Payment Policies

- Only **one** chiropractic care visit code is payable per day.
- Chiropractic care visit codes are payable in addition to E/M office visit codes **only when all of the following conditions are met:**
    - The E/M service is for the **initial visit** for a **new claim**, and
    - The E/M service constitutes a significant separately identifiable service that exceeds the usual pre and post service work included in the chiropractic care visits, and
    - Modifier -25 is added to the new patient E/M code, and
    - Supporting documentation describing the service(s) provided is included in the patient's record.
- Office visits in excess of 20 visits or 60 days require prior authorization.
- Modifier -22 will be individually reviewed when billed with chiropractic care visit local codes (2050A to 2052A). A report is required detailing the nature of the unusual service and the reason it was required. Payment will vary based on findings of the review. No payment will be made when this modifier is used for non-covered or bundled services (for example: application of hot or cold packs).
- When a reopening application is filed, the services required to complete the application will be paid regardless of the insurer's action on the application:
    - When performed on the same day as completion of the reopening application (local code 1041M), an E/M visit (with -25 modifier when a chiropractic treatment code is also billed) and covered diagnostic studies (including x-rays) will be paid.
    - Treatment procedures on the same date and subsequent to the application date will only be paid if the claim is reopened, as no treatment is payable on denied reopenings (closed claims).

For more information, please refer to WAC 296-23-195 and the "Specialty and Administrative Services" section in the current Medical Aid Rules and Fee Schedules.

CRNA

Type of Service:

Use Type of Service code "N" with CPT, HCPCS and Local Codes.

CRNA services will be paid at a maximum of ninety percent of the allowed fee that would otherwise be paid to a physician. The only modifiers that are valid for CRNAs are –QX and –QZ (see the "Anesthesia Modifiers" section in the current Medical Aid Rules and Fee Schedules.

CRNA services must be billed on a separate HCFA-1500 form from those of an anesthesiologist, since they each have their own modifiers and provider account numbers. This applies to CRNAs providing solo services as well as team care.

For more information, please refer to WACs 296-23-240 and –245.

Hospital ER/Professional Services

Type of Service:

Use Type of Service code "3" with CPT and HCPCS codes

Hospitals must submit charges for ambulance services and professional services provided by hospital staff physicians on the HCFA-1500 bill form using the provider account number(s) assigned by the department specifically for ambulance services and professional services.

For more information, please refer to Chapter 296-23A "Hospitals" section in the current Medical Aid Rules and Fee Schedules.

Laboratories

Type of Service:

Use Type of Service code "3" with CPT Codes

For more information, please refer to the "Specialty and Administrative Services" section in the current Medical Aid Rules and Fee Schedules.

Naturopath

Type of Service:

Use Type of Service code "D" with HCPCS Codes and Local Codes

For more information, please refer to the "Specialty and Administrative Services" section and WAC 296-23 in the current Medical Aid Rules and Fee Schedule.

Osteopathic Physician

Type of Service:

Use Type of Service code "3" with CPT, HCPCS and Local Codes

Only osteopathic physicians may bill osteopathic manipulative treatment (OMT) using CPT codes.
E/M office visit services are not to be routinely billed in conjunction with OMT. E/M office visit services may be billed in conjunction with OMT *only when all the following conditions are met:*

- When the E/M service constitutes a significant separately identifiable service that exceeds the usual pre- and post- service work included with OMT.
- There is documentation in a patient's record which supports the level of E/M billed.
- The E/M service is billed using the -25 modifier. *E/M codes billed on the same day as OMT codes without the -25 modifier will not be paid.*
- The E/M service may be caused or prompted by the same diagnosis as the OMT service. A separate diagnosis is not required for payment of E/M in addition to OMT services on the same day.

For more information, please refer to the "Washington RBRVS Payment Policies" section in the current Medical Aid Rules and Fee Schedules.

Outpatient Pain Management

Type of Service:

Use Type of Service code "3" with Local Codes 2000M – 2002M

Provider must have a signed contract with the department to provide these services.

The Contractor will bill its usual and customary (U&C) fee, whether it exceeds or is below the approved maximum fees per WAC 296-20-010.

The Contractor must document in the pain clinic program records the type, frequency, length and itemized billed charges for each service provided. The Department will have access to such records upon request.

The Contractor must indicate the period covered in the bill in the box labeled 24A on the HCFA-1500 form.

Panel Examiner

Type of Service:

Use Type of Service "3" with CPT and Local codes

Doctors who wish to perform Independent Medical Examinations for the department or self-insurers providing coverage to workers covered under Title 51 RCW must be approved examiners. Doctors must submit a completed department application to the Provider Review and Education Unit at the Department of Labor and Industries, PO Box 44322, Olympia, WA 98504 and receive the medical director's approval. Approved examiners will be included on the department's approved examiners list.

For more information, please refer to Chapter 296-23 in the current Medical Aid Rules and Fee Schedules.

Pathologist

Type of Service:

Use Type of Service code "3" with CPT
Use Type of Service code "9" with HCPCS and Local Codes

For more information, please refer to the "Specialty and Administrative Services" section in the current Medical Aid Rules and Fee Schedules.

Physical Therapist

Type of Service:

Use Type of Service code "P" with CPT and HCPCS Codes

After 12 treatments, you must get authorization from the attending physician and the claims manager.

For more information, please refer to WAC 296-23-220 and the "Washington RBRVS Payment Policies" section in the current Medical Aid Rules and Fee Schedules.

Physician and Physician Clinics

Type of Service:

Use Type of Service code "3" with CPT, HCPCS and Local Codes

For more information, please refer to the "Washington RBRVS Payment Policies" section in the current Medical Aid Rules and Fee Schedules.

Physician Assistants

Type of Service:

Use Type of Service code "3" with CPT Codes
Use Type of Service code "9" with HCPCS and Local Codes

Physician assistants must be certified to qualify for payment. Physician assistants must have valid individual L&I provider account numbers to be paid for services.

Consultation, impairment ratings and administrative or reporting services related to worker's compensation benefit determinations are not payable to physician assistants. Physician assistant services are paid to the supervising physician or employer at a maximum of ninety percent (90%) of the allowed fee.

Further information about physician assistant services and payment can be found in the Provider Bulletin 99-04 and WAC 296-20-01501.

Podiatric Physician

Type of Service:

Use Type of Service code "3" with CPT Codes
Use Type of Service code "9" with HCPCS and Local Codes

For more information, please refer to the "Washington RBRVS Payment Policies" section in the current Medical Aid Rules and Fee Schedules.

Psychologist

Type of Service:

Use Type of Service code "3" with CPT Codes

A psychiatrist can only be the attending physician on a claim when a psychiatric condition is the **only condition** being treated, and it has been accepted by the department. Psychologists can not be the attending physician and may not certify time loss or rate Permanent Partial Disability under our rules (WAC 296-20-210).

Psychiatric evaluation and treatment services provided by social workers, psychiatric nurse practitioners, and other master's level counselors are **not covered**, even when delivered under the direct supervision of a clinical psychologist or a psychiatrist. Psychological testing may be administered by staff supervised by a psychiatrist or licensed clinical psychologist. However, the interpretation of testing and preparation of reports must be performed by the psychiatrist or licensed clinical psychologist.

Please refer to WAC 296-21-270, WAC 296-21-280 and "Washington RBRVS Payment Policies" section of the current Medical Aid Rules and Fee Schedules for more information.

Radiologist

Type of Service:

Use Type of Service code "3" with CPT, HCPCS and Local Codes

RT and LT Modifiers
HCPCS modifiers -RT (right side) and -LT (left side) *do not affect payment*, but may be used with CPT radiology codes (CPT codes 70010 – 79999) to identify duplicate procedures performed on opposite sides of the body.

Consultation Services
CPT code 76140, x-ray consultation, is not covered. For radiology codes where a consultation service is performed, providers should bill the specific x-ray code along with the local modifier -1R.

For more information, please refer to Chapter 296-23-135, -140, -145 and the "Washington RBRVS Payment Policies" section in the current Medical Aid Rules and Fee Schedules.

COMPLETING THE "HCFA-1500" FORM

Completed bill forms **must** be typed or printed and be clearly legible. All of the following boxes must be completed to ensure correct bill adjudication. Use the instructions below to complete the HCFA-1500 Health Insurance Claim Form.

The HCFA-1500 is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing Labor and Industries. (The numbered boxes on the claim form are referred to as fields.) Only those fields, which pertain to billing Labor and Industries, are addressed below.

DO NOT WRITE, PRINT, OR STAPLE ANY ATTACHMENTS IN THE BAR CODE AREA AT THE TOP OF THE FORM.

FIELD **DESCRIPTION / INSTRUCTIONS FOR COMPLETION**

la. **INSURED'S I.D. NO.:** Enter worker's social security number. This information will assist us in identifying the injured worker's claim number if the claim number is missing or invalid.

2. **PATIENT'S NAME:** Enter injured worker's last name, first name, and middle initial.

3. **PATIENT'S BIRTH DATE:** List the birth date of the worker.

5. **PATIENT'S ADDRESS:** Enter worker's current address.

11. **INSURED'S POLICY GROUP OR FECA (Federal Employees Compensation Act) NUMBER:** Enter worker's L&I claim number. Omission of this number will result in denial of payment.

Claim numbers are alpha-numeric, consisting of seven characters. The letter identifies the funding source which is listed below.

STATE FUND INDUSTRIAL INSURANCE — Claim numbers are six digits, preceded by the letter "B, C, F, G, H, J, K, L, M, N, P, X or Y."

Send bills for State Fund claims to:

Department of Labor and Industries
PO Box 44269
Olympia WA 98504-4269

CRIME VICTIMS — Crime Victim Compensation Program claim numbers are either six digits preceded by a "V", or five digits preceded by a "VA, VB, VC, VH or VJ".

Send bills for Crime Victims claims to:

Department of Labor and Industries
Crime Victims Compensation Program
PO Box 44520
Olympia WA 98504-4520

SELF-INSURANCE

Self-Insurance claim numbers are six digits preceded by an "S, T or W". Bills for all Self-Insurance claims should be sent directly to the employer or their service company. Department bill forms, self-insured forms, or other forms acceptable to the self-insurer may be used.

14. **DATE OF INJURY/ILLNESS:** The date of injury/illness positively identifies each claim. This is important and must be included. A worker may have several claims; therefore, it is vital the proper claim is identified and charged for services provided.

17. **NAME OF REFERRING PHYSICIAN:** Enter the name of the doctor referring the worker to you, if applicable.

l7a. **I.D. NUMBER OF REFERRING PHYSICIAN OR OTHER SOURCE:** This information is required if you have not listed ICD9-CM diagnosis codes in box 21 or 24E.

21. **DIAGNOSIS OR NATURE OF INJURY OR ILLNESS:** You may use this space to describe in more detail ICD-9 description or multiple diagnosis. You must fill in specific diagnosis on line 24E for each line item. **Designate left or right side of body, when applicable.**

24. **ENTER ONLY 1 (ONE) SERVICE PER LINE**

24a. **DATE OF SERVICE:** Enter numerically the month, day, and year of service (e.g., January 04, 2000 = 010400). When billing for more than one date of service, only consecutive days may be billed on the same line. If dates of service are not consecutive, list each date on a separate line.

Example: Office visits made on January 3, 4, and 5 may be billed as one entry: 010300 - 010500. A "3" is entered in the units column (24g). However, office calls made on January 2, 4, and 8 should be listed on separate lines. A "1" should be entered in the units column for each date.

24b. **PLACE OF SERVICE: Do not use the Place of Service codes listed on the back of the HCFA-1500 forms not obtained from our department.** Enter required 2-digit place of service code. See list of codes in the Place of Service section of this booklet.

24c. **TYPE OF SERVICE:** Enter the appropriate Type of Service code. The necessary number or character is contained below. Different types of service require different Type of Service codes. Refer to provider specific instructions

Type of Service	For which Provider
C	**Chiropractors**
3	**Medical Services: Physicians/Physician Assistants, Psychologist, Osteopathic Physicians, Laboratories, Pathology, Radiology, Outpatient Pain Management Programs, Anesthesiologists**
N	**Advanced Registered Nurse Practitioners,**

	Certified Registered Nurse Anesthetists
D	**Drugless Therapist: Naturopaths**
P	**Physical Therapist**

24d. **PROCEDURE, SERVICE, OR SUPPLY:** Identify the procedure (CPT/HCPCS/Local Code) performed. Enter only one code per line.

Please Note: The department does not publish sufficient descriptive CPT and HCPCS information to properly code provided services, since it is already available in these books. Providers and self-insurers must refer to their own copies of these books to determine the appropriate code(s) to use for billing and payment.

ATTN: All Providers – If service is listed as bundled in the fee schedule, DO NOT include it on the bill form. Codes that are determined as bundled by the department, will be automatically denied.

CODE MODIFIER: A modifier indicates a performed service or procedure has been altered by a specific circumstance. A complete list of procedure code modifiers can be found in the RBRVS & Anesthesia Section of the Fee Schedule. Indicate modifier, if applicable, after the procedure code. Example: 20816-80.

DESCRIPTION OF SERVICES: Describe services provided, e.g., apply long leg cast. When service is coded "unlisted" in CPT-IV, the treatment or diagnostic study must be fully described.

24e. **ICD-9-CM DIAGNOSIS CODE NUMBER:** One code must be recorded in this box for each line item if you do not provide referring physician ID number (in box 17a).

24f. **CHARGES:** Enter your usual and customary fee for the procedure billed on this line. (Do NOT bill negative charges)

24g. **DAYS OR UNITS:** Enter the total number of units, minutes, or days for the services billed on a line.

25. **FEDERAL TAX I.D. NUMBER:** Required. If the L&I provider account number is missing or invalid, this information helps to identify the correct provider for payment.

26. **PATIENT'S ACCOUNT NO.:** The number you use to identify your patient's account. This is for your convenience only.

28. **TOTAL CHARGES:** Total of all charges.

31. **SIGNATURE:** Signature may be that of the provider or the person preparing the bill. Regardless of who signs the bill, the provider submitting the bill is responsible for its accuracy. For computer generated bills, the signature may be left blank. The "DATE" is the date the bill is prepared and sent to the department or self-insurer.

32. **NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED:** Physical location where services were rendered.

33. **PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE, AND PHONE** #: Enter the name of the provider providing the services (enter last name first) and current address. If there are any changes in the provider's address or status, immediately notify Provider Accounts in writing or via fax at the following address/fax number:

Provider Accounts
Department of Labor and Industries
PO Box 44261
Olympia WA 98504-4261
Fax 360-902-4484

PLEASE INCLUDE THE L&I PROVIDER ACCOUNT NUMBER(S) YOU'RE SUBMITTING A CHANGE FOR ON YOUR CORRESPONDENCE.

Indicating a new address on the bill will not change the department's record of your address and could delay payment.

PIN #: Enter the L&I provider account number assigned by L&I for the performing provider of service. Failure to enter your performing providers L&I provider account number will result in the bill being returned and/or denied.

GROUP #: If payment is to be made to a group/clinic or supervising physician (Payee) rather than the provider performing the service, you must enter the group/clinic or supervising physician's (Payee) account number designated by L&I. Include the first two characters of the group/clinic name or the first two characters of the supervising physician's last name. The name must correspond with the account number used.

29. This applies only to the provider groups where the group/clinic has been assigned a **main L&I provider account number (Payee)** and the members of the group have been assigned individual L&I provider account numbers.

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PLEASE PRINT OR TYPE

L&I HEALTH INSURANCE CLAIM FORM

DEPARTMENT OF LABOR AND INDUSTRIES
CLAIMS SECTION
PO BOX 44269
OLYMPIA WA 98504-4269

PICA

PICA

1. L&I (ID) ☐		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX MM DD YY M ☐ F ☐	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street)
CITY / STATE	8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐	CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code)		ZIP CODE / TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State) |____| C. OTHER ACCIDENT? ☐ YES ☐ NO	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. INSURED'S DATE OF BIRTH SEX MM DD YY M ☐ F ☐
b. OTHER INSURED'S DATE OF BIRTH SEX MM DD YY M ☐ F ☐		b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO **If yes,** return to and complete item 9 a-d.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE – I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE – I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____
14. DATE OF CURRENT: MM DD YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY MM DD YY FROM TO
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES TO CURRENT SERVICES MM DD YY MM DD YY FROM TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) ----------↓ 1. |_____ . ____ 3. |_____ . ____ 2. |_____ . ____ 4. |_____ . ____		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE MM DD YY MM DD YY	B PLACE OF SERVICE	C Type Of Service	D PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G Days Or Units	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE

25. FEDERAL TAX I.D. NUMBER SSN EIN ☐ ☐	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? ☐ YES ☐ NO
28. TOTAL CHARGE $	29. AMOUNT PAID $	30. BALANCE DUE $
31. PHYSICIAN/SUPPLIER SIGNATURE INCLUDING DEGREES OR CREDENTIALS – (I certify that I understand L&I billing instructions, that information contained on this bill is consistent with those instructions and accurate to the best of my knowledge.) SIGNED DATE	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE PROVIDED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE AND PHONE # PIN # | GRP #

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICES 8/88)
f245-127-000 (3/92)

L&I PROVIDER ACCOUNT # ⬆

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PLEASE PRINT OR TYPE

Sample: ASC WITHOUT IMPLANT

L&I HEALTH INSURANCE CLAIM FORM

DEPARTMENT OF LABOR AND INDUSTRIES
CLAIMS SECTION
PO BOX 44269
OLYMPIA WA 98504-4269

PICA | PICA

1. L&I (ID)	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 000-00-0000 (SSN)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, Jane	3. PATIENT'S BIRTH DATE SEX XX XX XX M ☐ F ☒
5. PATIENT'S ADDRESS (No., Street) 151 Oak Creek Lane	6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐
CITY: Morton — STATE: WA	8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐
ZIP CODE: 98519 — TELEPHONE (Include Area Code): (360) 000-0000	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State) |____| C. OTHER ACCIDENT? ☐ YES ☐ NO
a. OTHER INSURED'S POLICY OR GROUP NUMBER	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐	
c. EMPLOYER'S NAME OR SCHOOL NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE

CITY — STATE	11. INSURED'S POLICY GROUP OR FECA NUMBER Y 000000 (L&I Claim #)
ZIP CODE — TELEPHONE (Include Area Code): ( )	a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐
7. INSURED'S ADDRESS (No., Street)	b. EMPLOYER'S NAME OR SCHOOL NAME XYZ Company
	c. INSURANCE PLAN NAME OR PROGRAM NAME
	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO **If yes,** return to and complete item 9 a-d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE – I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE – I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY XX | XX | XX ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE Xxxxxx Xxxxxx MD	17a. I.D. NUMBER OF REFERRING PHYSICIAN 0000000
19. RESERVED FOR LOCAL USE	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM | | TO MM DD YY 18. HOSPITALIZATION DATES TO CURRENT SERVICES MM DD YY FROM | | TO MM DD YY 20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES |
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) ----------▼ 1. XXX.XX 3. |_____ . ____ 2. |_____ . ____ 4. |_____ . ____	22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. | 23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE MM DD YY MM DD YY	B PLACE OF SERVICE	C Type Of Service	D PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G Days Or Units	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
01 | 01 | 02 01 | 01 | 02	24	3	XXXXX | SG | XX	XXX.XX	XXX | XX	1				
| | | |			| |		|					
| | | |			| |		|					
| | | |			| |		|					
| | | |			| |		|					
| | | |			| |		|					

25. FEDERAL TAX I.D. NUMBER SSN EIN 00-0000000 ☐ ☒	26. PATIENT'S ACCOUNT NO. Optional	27. ACCEPT ASSIGNMENT? ☐ YES ☐ NO	28. TOTAL CHARGE $ XXX | XX 29. AMOUNT PAID $ | 30. BALANCE DUE $ |

31. PHYSICIAN/SUPPLIER SIGNATURE INCLUDING DEGREES OR CREDENTIALS – (I certify that I understand L&I billing instructions, that information contained on this bill is consistent with those instructions and accurate to the best of my knowledge.) WWWWWWW WWWWWWWWWWW XX/XX/XX SIGNED DATE	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE PROVIDED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE AND PHONE # Ambulatory Surgery Center 3112 Xxxxxxx Lane Morton WA 98519 (360) 000-0000 PIN # 0000000 | GRP # 0000000

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICES 8/88)
f245-127-000 (3/92)

L&I PROVIDER ACCOUNT # ⬆

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PLEASE PRINT OR TYPE

Sample: ASC WITH IMPLANT

L&I HEALTH INSURANCE CLAIM FORM

DEPARTMENT OF LABOR AND INDUSTRIES
CLAIMS SECTION
PO BOX 44269
OLYMPIA WA 98504-4269

PICA | PICA

1.	L&I (ID) ☐	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 000-00-0000 (SSN)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, Jane	3. PATIENT'S BIRTH DATE SEX XX XX XX M ☐ F ☒	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street) 151 Oak Creek Lane	6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street)
CITY: Morton / STATE: WA	8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐	CITY / STATE
ZIP CODE: 98519 / TELEPHONE (Include Area Code): (360) 000-0000		ZIP CODE / TELEPHONE (Include Area Code): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO	11. INSURED'S POLICY GROUP OR FECA NUMBER Y 000000 (L&I Claim #)
a. OTHER INSURED'S POLICY OR GROUP NUMBER	b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State) |____|	a. INSURED'S DATE OF BIRTH MM DD YY / SEX M ☐ F ☐
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M ☐ F ☐	C. OTHER ACCIDENT? ☐ YES ☐ NO	b. EMPLOYER'S NAME OR SCHOOL NAME XYZ Company
c. EMPLOYER'S NAME OR SCHOOL NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO **If yes,** return to and complete item 9 a-d.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE – I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE – I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____
14. DATE OF CURRENT: MM DD YY XX | XX | XX ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM | | TO MM DD YY | |
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES TO CURRENT SERVICES MM DD YY FROM | | | TO MM DD YY | | |
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? ☐ YES ☐ NO | $ CHARGES |
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) ↓ 1. |_____ . ____ 3. |_____ . ____ 2. |_____ . ____ 4. |_____ . ____		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO. | 23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE FROM MM DD YY	TO MM DD YY	B PLACE OF SERVICE	C Type Of Service	D PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G Days Or Units	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
01 | 01 | 02	01 | 01 | 02	24	3	XXXXX	SG | XX	XXX.XX	XXX | XX	1				
01 | 01 | 02	01 | 01 | 02	24	3	XXXXX	SG |	XXX.XX	XXX | XX	1				
			↑ IMPLANT HCPCS CODE									

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
00-0000000 ☐ ☒	Optional	☐ YES ☐ NO	$ XXX | XX	$ |	$ |

31. PHYSICIAN/SUPPLIER SIGNATURE INCLUDING DEGREES OR CREDENTIALS – (I certify that I understand L&I billing instructions, that information contained on this bill is consistent with those instructions and accurate to the best of my knowledge.) WWWWWWW WWWWWWWWWW XX/XX/XX SIGNED DATE	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE PROVIDED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE AND PHONE # Ambulatory Surgery Center 3112 Xxxxxxx Lane Morton WA 98519 (360) 000-0000 PIN # 0000000 | GRP # 0000000

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICES 8/88)
f245-127-000 (3/92)

L&I PROVIDER ACCOUNT # ⬆

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PLEASE PRINT OR TYPE

Sample: ASC INJECTION PROCEDURE

L&I HEALTH INSURANCE CLAIM FORM

DEPARTMENT OF LABOR AND INDUSTRIES
CLAIMS SECTION
PO BOX 44269
OLYMPIA WA 98504-4269

PICA | PICA

1. L&I (ID)		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 000-00-0000 (SSN)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, Jane	3. PATIENT'S BIRTH DATE SEX XX XX XX M ☐ F ☒	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street) 151 Oak Creek Lane	6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street)
CITY: Morton / STATE: WA	8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐	CITY / STATE
ZIP CODE: 98519 / TELEPHONE (Include Area Code): (360) 000-0000		ZIP CODE / TELEPHONE (Include Area Code): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO	11. INSURED'S POLICY GROUP OR FECA NUMBER Y 000000 (L&I Claim #)
a. OTHER INSURED'S POLICY OR GROUP NUMBER	b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State) |____|	a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐	C. OTHER ACCIDENT? ☐ YES ☐ NO	b. EMPLOYER'S NAME OR SCHOOL NAME XYZ Company
c. EMPLOYER'S NAME OR SCHOOL NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO **If yes,** return to and complete item 9 a-d.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE – I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE – I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____
14. DATE OF CURRENT: MM DD YY XX | XX | XX ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY MM DD YY FROM | | | TO | | |
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE Xxxxxx Xxxxxx MD	17a. I.D. NUMBER OF REFERRING PHYSICIAN 0000000	18. HOSPITALIZATION DATES TO CURRENT SERVICES MM DD YY MM DD YY FROM | | | TO | | |
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? ☐ YES ☐ NO | | $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) ----------↓ 1. XXX.XX 3. |_____ . ____ 2. |_____ . ____ 4. |_____ . ____		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. | 23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE MM DD YY MM DD YY	B PLACE OF SERVICE	C Type Of Service	D PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G Days Or Units	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
01 | 01 | 02 01 | 01 | 02	24	3	1st level XXXXX | SG |	XXX.XX	XXX | XX	1				
01 | 01 | 02 01 | 01 | 02	24	3	XXXXX | SG | 50	XXX.XX	Full charge XXX | XX	1				
01 | 01 | 02 01 | 01 | 02	24	3	2nd level XXXXX | SG |	XXX.XX	XXX | XX	1				
01 | 01 | 02 01 | 01 | 02	24	3	XXXXX | SG | 50	XXX.XX	Full Charge XXX | XX	1				
01 | 01 | 02 01 | 01 | 02	24	3	76005 | TC |	XXX.XX	XXX | XX	1				
| | | |			| |		|					

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
00-0000000 ☐ ☒	Optional	☐ YES ☐ NO	$ XXXX | XX	$ |	$ |

31. PHYSICIAN/SUPPLIER SIGNATURE INCLUDING DEGREES OR CREDENTIALS – (I certify that I understand L&I billing instructions, that information contained on this bill is consistent with those instructions and accurate to the best of my knowledge.)	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE PROVIDED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE AND PHONE #
WWWWWWW WWWWWWWWWWW XX/XX/XX SIGNED DATE		Ambulatory Surgery Center 3112 Xxxxxxx Lane Morton WA 98519 (360) 000-0000 PIN # 0000000 | GRP # 0000000

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICES 8/88)
f245-127-000 (3/92)

L&I PROVIDER ACCOUNT # ⬆

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PLEASE PRINT OR TYPE

L&I HEALTH INSURANCE CLAIM FORM

DEPARTMENT OF LABOR AND INDUSTRIES
CLAIMS SECTION
PO BOX 44269
OLYMPIA WA 98504-4269

Sample: Anesthesiologist

PICA | PICA

1. | ☐ L&I (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 000-00-0000 (SSN)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe, Jane

3. PATIENT'S BIRTH DATE SEX: MM DD YY | M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 151 Oak Creek Lane

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: Morton | STATE: WA

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐

CITY | STATE

ZIP CODE: 98519 | TELEPHONE (Include Area Code): (360) 000-0000

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

ZIP CODE | TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. OTHER INSURED'S DATE OF BIRTH SEX: MM DD YY | M ☐ F ☐

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State) |____|

C. OTHER ACCIDENT? ☐ YES ☐ NO

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER: Y 000000 (L&I Claim #)

a. INSURED'S DATE OF BIRTH SEX: MM DD YY | M ☐ F ☐

b. EMPLOYER'S NAME OR SCHOOL NAME: XYZ Company

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO **If yes,** return to and complete item 9 a-d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE – I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE – I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY | ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM | | TO MM DD YY | |

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Xxxxxx Xxxxxx MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 0000000

18. HOSPITALIZATION DATES TO CURRENT SERVICES MM DD YY FROM | | TO MM DD YY | |

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES |

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) ↓

1. XXX.XX
2. |_____ . ____
3. |_____ . ____
4. |_____ . ____

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO. |

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE MM DD YY MM DD YY	B PLACE OF SERVICE	C Type Of Service	D PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G Days Or Units	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
03 | 01 | 01 03 | 01 | 01	XX	3	XXXXX | XX	XXX.XX	XX | XX	20 Min.				

25. FEDERAL TAX I.D. NUMBER SSN EIN: 00-0000000 ☐ ☒

26. PATIENT'S ACCOUNT NO.: Optional

27. ACCEPT ASSIGNMENT? ☐ YES ☐ NO

28. TOTAL CHARGE: $ XX \| XX

29. AMOUNT PAID: $ |

30. BALANCE DUE: $ |

31. PHYSICIAN/SUPPLIER SIGNATURE INCLUDING DEGREES OR CREDENTIALS – (I certify that I understand L&I billing instructions, that information contained on this bill is consistent with those instructions and accurate to the best of my knowledge.)

SIGNED XXXXXXXX DATE XX/XX/XX

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE PROVIDED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE AND PHONE #
Xxxxxx Xxxxxxxxx MD
3112 Xxxxxx Lane
Morton, WA 98519 (XXX) XXX-XXXX
PIN # 0000000 | GRP # 0000000

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICES 8/88)
f245-127-000 (3/92)

L&I PROVIDER ACCOUNT # ⬆

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RI [illegible]

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PLEASE PRINT OR TYPE

L&I HEALTH INSURANCE CLAIM FORM

DEPARTMENT OF LABOR AND INDUSTRIES
CLAIMS SECTION
PO BOX 44269
OLYMPIA WA 98504-4269

Sample: Chiropractor

PICA

1.		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
L&I (ID) ☐		000-00-0000 (SSN)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, Jane	3. PATIENT'S BIRTH DATE SEX MM DD YY M ☐ F ☒	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street) 151 Oak Creek Lane	6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street)
CITY: Morton — STATE: WA	8. PATIENT STATUS Single ☐ Married ☐ Other ☐	CITY — STATE
ZIP CODE: 98519 — TELEPHONE (Include Area Code): (360) 000-0000	Employed ☐ Full-Time Student ☐ Part-Time Student ☐	ZIP CODE — TELEPHONE (Include Area Code): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO	11. INSURED'S POLICY GROUP OR FECA NUMBER Y 000000 (L& I Claim #)
a. OTHER INSURED'S POLICY OR GROUP NUMBER	b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State) |____|	a. INSURED'S DATE OF BIRTH SEX MM DD YY M ☐ F ☐
b. OTHER INSURED'S DATE OF BIRTH SEX MM DD YY M ☐ F ☐	C. OTHER ACCIDENT? ☐ YES ☐ NO	b. EMPLOYER'S NAME OR SCHOOL NAME XYZ Company
c. EMPLOYER'S NAME OR SCHOOL NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO **If yes,** return to and complete item 9 a-d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE – I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE – I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM | | | TO MM DD YY | | |
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE Xxxxxx Xxxxxx MD	17a. I.D. NUMBER OF REFERRING PHYSICIAN 0000000	18. HOSPITALIZATION DATES TO CURRENT SERVICES MM DD YY FROM | | | TO MM DD YY | | |
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES | |
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) ↓ 1. XXX.XX 3. |_____ . ____ 2. |_____ . ____ 4. |_____ . ____		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. | 23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE MM DD YY MM DD YY	B PLACE OF SERVICE	C Type Of Service	D PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G Days Or Units	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
03 | 01|01 03 | 01|01	XX	C	XXXXX | XX |	XXX.XX	XX | XX	1				
03 | 01|01 03 | 01|01	XX	C	XXXXX | XX |	XXX.XX	XX | XX	1				
| | | |			| |		|					
| | | |			| |		|					
| | | |			| |		|					
| | | |			| |		|					

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
00-0000000 ☐ ☒	Optional	☐ YES ☐ NO	$ XX | XX	$ |	$ |

31. PHYSICIAN/SUPPLIER SIGNATURE INCLUDING DEGREES OR CREDENTIALS – (I certify that I understand L&I billing instructions, that information contained on this bill is consistent with those instructions and accurate to the best of my knowledge.) SIGNED XXXXXXXX DATE XX/XX/XX	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE PROVIDED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE AND PHONE # Xxxxxx Xxxxxxxxx DC 3112 Xxxxxx Lane Morton, WA 98519 (XXX) XXX-XXXX PIN # 0000000 | GRP # 0000000

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICES 8/88)
f245-127-000 (3/92)

L&I PROVIDER ACCOUNT # ⬆

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PLEASE PRINT OR TYPE

Sample: CRNA

L&I HEALTH INSURANCE CLAIM FORM

DEPARTMENT OF LABOR AND INDUSTRIES
CLAIMS SECTION
PO BOX 44269
OLYMPIA WA 98504-4269

PICA

1.		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
L&I (ID) ☐		000-00-0000 (SSN)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, Jane	3. PATIENT'S BIRTH DATE SEX MM DD YY M ☐ F ☒	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street) 151 Oak Creek Lane	6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street)
CITY: Morton — STATE: WA	8. PATIENT STATUS Single ☐ Married ☐ Other ☐	CITY — STATE
ZIP CODE: 98519 — TELEPHONE (Include Area Code): (360) 000-0000	Employed ☐ Full-Time Student ☐ Part-Time Student ☐	ZIP CODE — TELEPHONE (Include Area Code): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO	11. INSURED'S POLICY GROUP OR FECA NUMBER Y 000000 (L& I Claim #)
a. OTHER INSURED'S POLICY OR GROUP NUMBER	b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State) |____|	a. INSURED'S DATE OF BIRTH SEX MM DD YY M ☐ F ☐
b. OTHER INSURED'S DATE OF BIRTH SEX MM DD YY M ☐ F ☐	C. OTHER ACCIDENT? ☐ YES ☐ NO	b. EMPLOYER'S NAME OR SCHOOL NAME XYZ Company
c. EMPLOYER'S NAME OR SCHOOL NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO **If yes,** return to and complete item 9 a-d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE – I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE – I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM | | TO MM DD YY | |
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE Xxxxxx Xxxxxx MD	17a. I.D. NUMBER OF REFERRING PHYSICIAN 0000000	18. HOSPITALIZATION DATES TO CURRENT SERVICES MM DD YY FROM | | TO MM DD YY | |
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES | |
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) ↓ 1. XXX.XX 3. |_____ . ____ 2. |_____ . ____ 4. |_____ . ____		22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO. | 23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE MM DD YY MM DD YY	B PLACE OF SERVICE	C Type Of Service	D PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G Days Or Units	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
03 | 01|01 03 | 01|01	XX	N	XXXXX | XX |	XXX.XX	XX | XX	1				
03 | 01|01 03 | 01|01	XX	N	XXXXX | XX |	XXX.XX	XX | XX	1				
| | | |			| |		|					
| | | |			| |		|					
| | | |			| |		|					
| | | |			| |		|					

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
00-0000000 ☐ ☒	Optional	☐ YES ☐ NO	$ XX | XX	$ |	$ |

31. PHYSICIAN/SUPPLIER SIGNATURE INCLUDING DEGREES OR CREDENTIALS – (I certify that I understand L&I billing instructions, that information contained on this bill is consistent with those instructions and accurate to the best of my knowledge.) SIGNED XXXXXXXX DATE XX/XX/XX	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE PROVIDED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE AND PHONE # Xxxxxx Xxxxxxxxx CRNA 3112 Xxxxxx Lane Morton, WA 98519 (XXX) XXX-XXXX PIN # 0000000 | GRP # 0000000

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICES 8/88)
f245-127-000 (3/92)

L&I PROVIDER ACCOUNT # ⬆

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

L&I HEALTH INSURANCE CLAIM FORM

DEPARTMENT OF LABOR AND INDUSTRIES
CLAIMS SECTION
PO BOX 44269
OLYMPIA WA 98504-4269

PLEASE PRINT OR TYPE **Sample: Hospital ER/Prof Svcs**

PICA | PICA

1. L&I (ID)		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 000-00-0000 (SSN)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, Jane	3. PATIENT'S BIRTH DATE SEX MM DD YY M ☐ F ☒	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street) 151 Oak Creek Lane	6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street)
CITY: Morton — STATE: WA	8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐	CITY — STATE
ZIP CODE: 98519 — TELEPHONE (Include Area Code): (360) 000-0000		ZIP CODE — TELEPHONE (Include Area Code): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State) |____| C. OTHER ACCIDENT? ☐ YES ☐ NO	11. INSURED'S POLICY GROUP OR FECA NUMBER Y 000000 (L& I Claim #)
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. INSURED'S DATE OF BIRTH SEX MM DD YY M ☐ F ☐
b. OTHER INSURED'S DATE OF BIRTH SEX MM DD YY M ☐ F ☐		b. EMPLOYER'S NAME OR SCHOOL NAME XYZ Company
c. EMPLOYER'S NAME OR SCHOOL NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO **If yes,** return to and complete item 9 a-d.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE – I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE – I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____
14. DATE OF CURRENT: MM DD YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM | | | TO MM DD YY | | |
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE Xxxxxx Xxxxxx MD	17a. I.D. NUMBER OF REFERRING PHYSICIAN 0000000	18. HOSPITALIZATION DATES TO CURRENT SERVICES MM DD YY FROM | | | TO MM DD YY | | |
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES | |
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) ----------↓ 1. XXX.XX 3. |_____ . ____ 2. |_____ . ____ 4. |_____ . ____		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. | 23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE MM DD YY MM DD YY	B PLACE OF SERVICE	C Type Of Service	D PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G Days Or Units	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
03 | 01|01 03 | 01|01	XX	3	XXXXX | |	XXX.XX	XX | XX	1				
03 | 01|01 03 | 01|01	XX	3	XXXXX | |	XXX.XX	XX | XX	1				
| | | |			| |		|					
| | | |			| |		|					
| | | |			| |		|					
| | | |			| |		|					

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
00-0000000 ☐ ☒	Optional	☐ YES ☐ NO	$ XX | XX	$ |	$ |

31. PHYSICIAN/SUPPLIER SIGNATURE INCLUDING DEGREES OR CREDENTIALS – (I certify that I understand L&I billing instructions, that information contained on this bill is consistent with those instructions and accurate to the best of my knowledge.) SIGNED XXXXXXXX DATE XX/XX/XX	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE PROVIDED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE AND PHONE # Good Health Hospital ER Physician 3112 Xxxxxx Lane Morton, WA 98519 (XXX) XXX-XXXX PIN # 0000000 | GRP # 0000000

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICES 8/88)
f245-127-000 (3/92)

L&I PROVIDER ACCOUNT # ⬆

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PLEASE PRINT OR TYPE

L&I HEALTH INSURANCE CLAIM FORM

DEPARTMENT OF LABOR AND INDUSTRIES
CLAIMS SECTION
PO BOX 44269
OLYMPIA WA 98504-4269

Sample: Laboratory

PICA | PICA

1. | L&I (ID) ☐

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 000-00-0000 (SSN)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe, Jane

3. PATIENT'S BIRTH DATE SEX: MM DD YY | M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 151 Oak Creek Lane

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: Morton | STATE: WA

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐

CITY | STATE

ZIP CODE: 98519 | TELEPHONE (Include Area Code): (360) 000-0000

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

ZIP CODE | TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: Y 000000 (L&I Claim #)

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH SEX: MM DD YY | M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH SEX: MM DD YY | M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State) |____|

b. EMPLOYER'S NAME OR SCHOOL NAME: XYZ Company

C. OTHER ACCIDENT? ☐ YES ☐ NO

c. EMPLOYER'S NAME OR SCHOOL NAME

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO **If yes,** return to and complete item 9 a-d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE – I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE – I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM | TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Xxxxxx Xxxxxx MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 0000000

18. HOSPITALIZATION DATES TO CURRENT SERVICES MM DD YY FROM | TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)

1. XXX.XX
2. |_____ . ____
3. |_____ . ____
4. |_____ . ____

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE MM DD YY MM DD YY	B PLACE OF SERVICE	C Type Of Service	D PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G Days Or Units	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
03 | 01|01 03 | 01|01	XX	3	XXXXX | |	XXX.XX	XX | XX	1				
03 | 01|01 03 | 01|01	XX	3	XXXXX | |	XXX.XX	XX | XX	1				
| | | |			| |		|					
| | | |			| |		|					
| | | |			| |		|					
| | | |			| |		|					

25. FEDERAL TAX I.D. NUMBER SSN EIN: 00-0000000 ☐ ☒

26. PATIENT'S ACCOUNT NO.: Optional

27. ACCEPT ASSIGNMENT? ☐ YES ☐ NO

28. TOTAL CHARGE: $ XX | XX

29. AMOUNT PAID: $ |

30. BALANCE DUE: $ |

31. PHYSICIAN/SUPPLIER SIGNATURE INCLUDING DEGREES OR CREDENTIALS – (I certify that I understand L&I billing instructions, that information contained on this bill is consistent with those instructions and accurate to the best of my knowledge.)

SIGNED XXXXXXXX DATE XX/XX/XX

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE PROVIDED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE AND PHONE #
Pacific Laboratories
3112 Xxxxxx Lane
Morton, WA 98519 (XXX) XXX-XXXX
PIN # 0000000 | GRP # 0000000

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICES 8/88)
f245-127-000 (3/92)

L&I PROVIDER ACCOUNT # ⬆

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PLEASE PRINT OR TYPE

L&I HEALTH INSURANCE CLAIM FORM

DEPARTMENT OF LABOR AND INDUSTRIES
CLAIMS SECTION
PO BOX 44269
OLYMPIA WA 98504-4269

Sample: Naturopath

PICA

1. L&I (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 000-00-0000 (SSN)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe, Jane

3. PATIENT'S BIRTH DATE MM DD YY SEX: M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 151 Oak Creek Lane

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY: Morton | STATE: WA

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐

CITY | STATE

ZIP CODE: 98519 | TELEPHONE (Include Area Code): (360) 000-0000

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

ZIP CODE | TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. OTHER INSURED'S DATE OF BIRTH SEX: MM DD YY M ☐ F ☐

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State) |____|

C. OTHER ACCIDENT? YES ☐ NO ☐

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER: Y 000000 (L&I Claim #)

a. INSURED'S DATE OF BIRTH MM DD YY SEX: M ☐ F ☐

b. EMPLOYER'S NAME OR SCHOOL NAME: XYZ Company

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ **If yes,** return to and complete item 9 a-d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE – I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE – I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Xxxxxx Xxxxxx MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 0000000

18. HOSPITALIZATION DATES TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)

1. XXX.XX
2. |_____ . ____
3. |_____ . ____
4. |_____ . ____

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE MM DD YY MM DD YY	B PLACE OF SERVICE	C Type Of Service	D PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G Days Or Units	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
03 | 01 | 01 03 | 01 | 01	XX	D	XXXXX	XXX.XX	XX | XX	1				

25. FEDERAL TAX I.D. NUMBER SSN EIN: 00-0000000 ☐ ☒

26. PATIENT'S ACCOUNT NO.: Optional

27. ACCEPT ASSIGNMENT? YES ☐ NO ☐

28. TOTAL CHARGE: $ XX | XX

29. AMOUNT PAID: $

30. BALANCE DUE: $

31. PHYSICIAN/SUPPLIER SIGNATURE INCLUDING DEGREES OR CREDENTIALS – (I certify that I understand L&I billing instructions, that information contained on this bill is consistent with those instructions and accurate to the best of my knowledge.)

SIGNED XXXXXXXX DATE XX/XX/XX

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE PROVIDED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE AND PHONE #
Xxxxxx Xxxxxx, ND
3112 Xxxxxx Lane
Morton, WA 98519 (XXX) XXX-XXXX
PIN # 0000000 | GRP # 0000000

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICES 8/88)
f245-127-000 (3/92)

L&I PROVIDER ACCOUNT #

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PLEASE PRINT OR TYPE

L&I HEALTH INSURANCE CLAIM FORM

DEPARTMENT OF LABOR AND INDUSTRIES
CLAIMS SECTION
PO BOX 44269
OLYMPIA WA 98504-4269

Sample: Osteopathic

PICA | PICA

1. L&I (ID)		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 000-00-0000 (SSN)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, Jane	3. PATIENT'S BIRTH DATE SEX MM DD YY M ☐ F ☒	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street) 151 Oak Creek Lane	6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street)
CITY: Morton — STATE: WA	8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐	CITY — STATE
ZIP CODE: 98519 — TELEPHONE (Include Area Code): (360) 000-0000		ZIP CODE — TELEPHONE (Include Area Code): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State) |____| C. OTHER ACCIDENT? ☐ YES ☐ NO	11. INSURED'S POLICY GROUP OR FECA NUMBER Y 000000 L&I Claim #)
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. INSURED'S DATE OF BIRTH SEX MM DD YY M ☐ F ☐
b. OTHER INSURED'S DATE OF BIRTH SEX MM DD YY M ☐ F ☐		b. EMPLOYER'S NAME OR SCHOOL NAME XYZ Company
c. EMPLOYER'S NAME OR SCHOOL NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO **If yes,** return to and complete item 9 a-d.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE – I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE – I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____
14. DATE OF CURRENT: MM DD YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM | | | TO MM DD YY | | |
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE Xxxxxx Xxxxxx MD	17a. I.D. NUMBER OF REFERRING PHYSICIAN 0000000	18. HOSPITALIZATION DATES TO CURRENT SERVICES MM DD YY FROM | | | TO MM DD YY | | |
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES | |
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) ↓ 1. XXX.XX 3. |_____ . ____ 2. |_____ . ____ 4. |_____ . ____		22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO. | 23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE MM DD YY MM DD YY	B PLACE OF SERVICE	C Type Of Service	D PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G Days Or Units	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
03 | 01|01 — 03 | 01|01	XX	3	XXXXX | XX |	XXX.XX	XX | XX	1				

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
00-0000000 ☐ ☒	Optional	☐ YES ☐ NO	$ XX | XX	$	$

31. PHYSICIAN/SUPPLIER SIGNATURE INCLUDING DEGREES OR CREDENTIALS – (I certify that I understand L&I billing instructions, that information contained on this bill is consistent with those instructions and accurate to the best of my knowledge.)	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE PROVIDED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE AND PHONE #
SIGNED XXXXXXXX DATE XX/XX/XX		Xxxxxx Xxxxxx, DO 3112 Xxxxxx Lane Morton, WA 98519 (XXX) XXX-XXXX PIN # 0000000 | GRP # 0000000

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICES 8/88)
f245-127-000 (3/92)

L&I PROVIDER ACCOUNT # ⬆

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PLEASE PRINT OR TYPE

L&I HEALTH INSURANCE CLAIM FORM

DEPARTMENT OF LABOR AND INDUSTRIES
CLAIMS SECTION
PO BOX 44269
OLYMPIA WA 98504-4269

Sample: Outpatient Pain Mgmt Pgm

PICA | PICA

1. L&I (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 000-00-0000 (SSN)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe, Jane

3. PATIENT'S BIRTH DATE MM DD YY — SEX: M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 151 Oak Creek Lane

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY: Morton — STATE: WA

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐

CITY — STATE

ZIP CODE: 98519 — TELEPHONE (Include Area Code): (360) 000-0000

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

ZIP CODE — TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: Y 000000 (L&I Claim #)

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY — SEX: M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX: M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State) |_____|

b. EMPLOYER'S NAME OR SCHOOL NAME: XYZ Company

c. EMPLOYER'S NAME OR SCHOOL NAME

C. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ **If yes,** return to and complete item 9 a-d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE – I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE – I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY — FROM — TO — MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Xxxxxx Xxxxxx MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 0000000

18. HOSPITALIZATION DATES TO CURRENT SERVICES MM DD YY — FROM — TO — MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)

1. XXX.XX
2. |_____ . ____
3. |_____ . ____
4. |_____ . ____

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B PLACE OF SERVICE	C Type Of Service	D PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G Days Or Units	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
03 | 01|01	03 | 01|01	XX	3	XXXXX		XXX.XX	XX | XX	1				
03| 30| 01	04 | 28|01	XX	3	XXXXX		XXX.XX	XXXX | XX	15				

25. FEDERAL TAX I.D. NUMBER SSN EIN: 00-0000000 ☐ ☒

26. PATIENT'S ACCOUNT NO.: Optional

27. ACCEPT ASSIGNMENT? YES ☐ NO ☐

28. TOTAL CHARGE: $ XXXX | XX

29. AMOUNT PAID: $

30. BALANCE DUE: $

31. PHYSICIAN/SUPPLIER SIGNATURE INCLUDING DEGREES OR CREDENTIALS – (I certify that I understand L&I billing instructions, that information contained on this bill is consistent with those instructions and accurate to the best of my knowledge.)

SIGNED XXXXXXXX DATE XX/XX/XX

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE PROVIDED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE AND PHONE #
Outpatient Pain Program
3112 Xxxxxx Lane
Morton, WA 98519 (XXX) XXX-XXXX
PIN # 0000000 | GRP # 0000000

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICES 8/88)
f245-127-000 (3/92)

L&I PROVIDER ACCOUNT #

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PLEASE PRINT OR TYPE

L&I HEALTH INSURANCE CLAIM FORM

DEPARTMENT OF LABOR AND INDUSTRIES
CLAIMS SECTION
PO BOX 44269
OLYMPIA WA 98504-4269

Sample: Panel Examiner

PICA

1. L&I (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
000-00-0000 (SSN)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
Doe, Jane

3. PATIENT'S BIRTH DATE SEX
MM DD YY M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)
151 Oak Creek Lane

6. PATIENT RELATIONSHIP TO INSURED
Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY: Morton | STATE: WA

8. PATIENT STATUS
Single ☐ Married ☐ Other ☐
Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE: 98519 | TELEPHONE (Include Area Code): (360) 000-0000

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. OTHER INSURED'S DATE OF BIRTH SEX
MM DD YY M ☐ F ☐

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:
a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO
b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State) |____|
C. OTHER ACCIDENT? ☐ YES ☐ NO

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER
Y 000000 (L&I Claim #)

a. INSURED'S DATE OF BIRTH SEX
MM DD YY M ☐ F ☐

b. EMPLOYER'S NAME OR SCHOOL NAME
XYZ Company

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
☐ YES ☐ NO **If yes,** return to and complete item 9 a-d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE – I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE – I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
MM DD YY FROM | | TO MM DD YY | | |

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
Xxxxxx Xxxxxx MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN
0000000

18. HOSPITALIZATION DATES TO CURRENT SERVICES
MM DD YY FROM | | TO MM DD YY | | |

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES | |

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)
1. XXX.XX
2. |_____ . ____
3. |_____ . ____
4. |_____ . ____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. |

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE MM DD YY MM DD YY	B PLACE OF SERVICE	C Type Of Service	D PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G Days Or Units	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
03 | 01|01 03 | 01|01	XX	3	XXXXX | |	XXX.XX	XX | XX	1				
| | | |			| |		|					
| | | |			| |		|					
| | | |			| |		|					
| | | |			| |		|					
| | | |			| |		|					

25. FEDERAL TAX I.D. NUMBER SSN EIN
00-0000000 ☐ ☒

26. PATIENT'S ACCOUNT NO.
Optional

27. ACCEPT ASSIGNMENT? ☐ YES ☐ NO

28. TOTAL CHARGE
$ XX \| XX

29. AMOUNT PAID
$ |

30. BALANCE DUE
$ |

31. PHYSICIAN/SUPPLIER SIGNATURE INCLUDING DEGREES OR CREDENTIALS – (I certify that I understand L&I billing instructions, that information contained on this bill is consistent with those instructions and accurate to the best of my knowledge.)
SIGNED XXXXXXXX DATE XX/XX/XX

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE PROVIDED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE AND PHONE #
IME Northwest
3112 Xxxxxx Lane
Morton, WA 98519 (XXX) XXX-XXXX
PIN # 0000000 | GRP # 0000000

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICES 8/88)
f245-127-000 (3/92)

L&I PROVIDER ACCOUNT # ⬆

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PLEASE PRINT OR TYPE

L&I HEALTH INSURANCE CLAIM FORM

DEPARTMENT OF LABOR AND INDUSTRIES
CLAIMS SECTION
PO BOX 44269
OLYMPIA WA 98504-4269

Sample: Pathology

PICA | PICA

1.		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
L&I (ID) ☐		000-00-0000 (SSN)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, Jane	3. PATIENT'S BIRTH DATE SEX MM DD YY M ☐ F ☒	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street) 151 Oak Creek Lane	6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street)
CITY: Morton — STATE: WA	8. PATIENT STATUS Single ☐ Married ☐ Other ☐	CITY — STATE
ZIP CODE: 98519 — TELEPHONE (Include Area Code): (360) 000-0000	Employed ☐ Full-Time Student ☐ Part-Time Student ☐	ZIP CODE — TELEPHONE (Include Area Code): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO	11. INSURED'S POLICY GROUP OR FECA NUMBER Y 000000 (L&I Claim #)
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. INSURED'S DATE OF BIRTH SEX MM DD YY M ☐ F ☐
b. OTHER INSURED'S DATE OF BIRTH SEX MM DD YY M ☐ F ☐	b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State) |____|	b. EMPLOYER'S NAME OR SCHOOL NAME XYZ Company
c. EMPLOYER'S NAME OR SCHOOL NAME	C. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO **If yes,** return to and complete item 9 a-d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE – I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE – I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM | | TO MM DD YY | |
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE Xxxxxx Xxxxxx MD	17a. I.D. NUMBER OF REFERRING PHYSICIAN 0000000	18. HOSPITALIZATION DATES TO CURRENT SERVICES MM DD YY FROM | | TO MM DD YY | |
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES | |
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) ↓ 1. XXX.XX 3. |_____ . ____ 2. |_____ . ____ 4. |_____ . ____		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. | 23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE MM DD YY MM DD YY	B PLACE OF SERVICE	C Type Of Service	D PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G Days Or Units	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
03 | 01|01 03 | 01|01	XX	3	XXXXX | |	XXX.XX	XX | XX	1				
03 | 01|01 03 | 01|01	XX	3	XXXXX | |	XXX.XX	XX | XX	1				
| | | |			| |		|					
| | | |			| |		|					
| | | |			| |		|					
| | | |			| |		|					

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
00-0000000 ☐ ☒	Optional	☐ YES ☐ NO	$ XX | XX	$ |	$ |

31. PHYSICIAN/SUPPLIER SIGNATURE INCLUDING DEGREES OR CREDENTIALS – (I certify that I understand L&I billing instructions, that information contained on this bill is consistent with those instructions and accurate to the best of my knowledge.)	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE PROVIDED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE AND PHONE #
SIGNED XXXXXXXX DATE XX/XX/XX		Pathology NW Inc 3112 Xxxxxx Lane Morton, WA 98519 (XXX) XXX-XXXX PIN # 0000000 | GRP # 0000000

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICES 8/88)
f245-127-000 (3/92)

L&I PROVIDER ACCOUNT # ⬆

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

L&I HEALTH INSURANCE CLAIM FORM

DEPARTMENT OF LABOR AND INDUSTRIES
CLAIMS SECTION
PO BOX 44269
OLYMPIA WA 98504-4269

PLEASE PRINT OR TYPE **Sample: Physical Therapy**

PICA

1. L&I (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 000-00-0000 (SSN)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe, Jane

3. PATIENT'S BIRTH DATE MM DD YY SEX: M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 151 Oak Creek Lane

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY: Morton — STATE: WA

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐

CITY — STATE

ZIP CODE: 98519 — TELEPHONE (Include Area Code): (360) 000-0000

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

ZIP CODE — TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: Y 000000 (L&I Claim #)

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX: M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX: M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State) |_____|

b. EMPLOYER'S NAME OR SCHOOL NAME: XYZ Company

c. EMPLOYER'S NAME OR SCHOOL NAME

C. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ **If yes,** return to and complete item 9 a-d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE – I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE – I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM | | TO MM DD YY | | |

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Xxxxxx Xxxxxx MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 0000000

18. HOSPITALIZATION DATES TO CURRENT SERVICES MM DD YY FROM | | TO MM DD YY | | |

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)

1. XXX.XX
2. |_____ . ____
3. |_____ . ____
4. |_____ . ____

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B PLACE OF SERVICE	C Type Of Service	D PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G Days Or Units	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
03 | 01|01	03 | 01|01	XX	P	XXXXX		XXX.XX	XX | XX	1				
03 | 01|01	03 | 01|01	XX	P	XXXXX		XXX.XX	XX | XX	1				

25. FEDERAL TAX I.D. NUMBER SSN EIN: 00-0000000 ☐ ☒

26. PATIENT'S ACCOUNT NO.: Optional

27. ACCEPT ASSIGNMENT? YES ☐ NO ☐

28. TOTAL CHARGE: $ XX | XX

29. AMOUNT PAID: $

30. BALANCE DUE: $

31. PHYSICIAN/SUPPLIER SIGNATURE INCLUDING DEGREES OR CREDENTIALS – (I certify that I understand L&I billing instructions, that information contained on this bill is consistent with those instructions and accurate to the best of my knowledge.)

SIGNED XXXXXXXX DATE XX/XX/XX

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE PROVIDED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE AND PHONE #
Xxxxxx Xxxxxx, PT
3112 Xxxxxx Lane
Morton, WA 98519 (XXX) XXX-XXXX
PIN # 0000000 | GRP # 0000000

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICES 8/88)
f245-127-000 (3/92)

L&I PROVIDER ACCOUNT #

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PLEASE PRINT OR TYPE

Sample Physician

L&I HEALTH INSURANCE CLAIM FORM

DEPARTMENT OF LABOR AND INDUSTRIES
CLAIMS SECTION
PO BOX 44269
OLYMPIA WA 98504-4269

PICA | PICA

1. L&I (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
000-00-0000 (SSN)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
Doe, Jane

3. PATIENT'S BIRTH DATE SEX
MM DD YY M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)
151 Oak Creek Lane

6. PATIENT RELATIONSHIP TO INSURED
Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY: Morton | STATE: WA

8. PATIENT STATUS
Single [ ] Married [ ] Other [ ]
Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY | STATE

ZIP CODE: 98519 | TELEPHONE (Include Area Code): (360) 000-0000

ZIP CODE | TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. OTHER INSURED'S DATE OF BIRTH SEX
MM DD YY M [ ] F [ ]

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State) |_____|

C. OTHER ACCIDENT? YES [ ] NO [ ]

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER
Y 000000 (L&I Claim #)

a. INSURED'S DATE OF BIRTH SEX
MM DD YY M [ ] F [ ]

b. EMPLOYER'S NAME OR SCHOOL NAME
XYZ Company

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] **If yes,** return to and complete item 9 a-d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE – I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE – I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY | | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY | | |

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM | | | TO MM DD YY | | |

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
Xxxxxx Xxxxxx MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN
0000000

18. HOSPITALIZATION DATES TO CURRENT SERVICES MM DD YY FROM | | | TO MM DD YY | | |

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES | |

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) ----------↓

1. XXX.XX
2. |_____ . ____
3. |_____ . ____
4. |_____ . ____

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO. |

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE MM DD YY MM DD YY	B PLACE OF SERVICE	C Type Of Service	D PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G Days Or Units	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
03 | 01|01 03 | 01|01	XX	3	XXXXX | XX |	XXX.XX	XX | XX	1				
03 | 01|01 03 | 01|01	XX	3	XXXXX | XX |	XXX.XX	XX | XX	1				

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [X]
00-0000000

26. PATIENT'S ACCOUNT NO.
Optional

27. ACCEPT ASSIGNMENT? YES [ ] NO [ ]

28. TOTAL CHARGE
$ XX | XX

29. AMOUNT PAID
$ |

30. BALANCE DUE
$ |

31. PHYSICIAN/SUPPLIER SIGNATURE INCLUDING DEGREES OR CREDENTIALS – (I certify that I understand L&I billing instructions, that information contained on this bill is consistent with those instructions and accurate to the best of my knowledge.)

SIGNED XXXXXXXX DATE XX/XX/XX

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE PROVIDED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE AND PHONE #
Xxxxxx Xxxxxx, MD/Medical Clinic
3112 Xxxxxx Lane
Morton, WA 98519 (XXX) XXX-XXXX
PIN # 0000000 | GRP # 0000000

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICES 8/88)
f245-127-000 (3/92)

L&I PROVIDER ACCOUNT # ⬆

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

L&I HEALTH INSURANCE CLAIM FORM

DEPARTMENT OF LABOR AND INDUSTRIES
CLAIMS SECTION
PO BOX 44269
OLYMPIA WA 98504-4269

PLEASE PRINT OR TYPE

Sample: Physician Assistant

PICA

1.	L&I (ID) ☐
1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)	000-00-0000 (SSN)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	Doe, Jane
3. PATIENT'S BIRTH DATE SEX	MM DD YY M ☐ F ☒
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street)	151 Oak Creek Lane
6. PATIENT RELATIONSHIP TO INSURED	Self ☐ Spouse ☐ Child ☐ Other ☐
7. INSURED'S ADDRESS (No., Street)	
CITY / STATE	Morton / WA
8. PATIENT STATUS	Single ☐ Married ☐ Other ☐
CITY / STATE	
ZIP CODE / TELEPHONE (Include Area Code)	98519 / (360) 000-0000
	Employed ☐ Full-Time Student ☐ Part-Time Student ☐
ZIP CODE / TELEPHONE (Include Area Code)	( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	
10. IS PATIENT'S CONDITION RELATED TO:	a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO
11. INSURED'S POLICY GROUP OR FECA NUMBER	Y 000000 (L&I Claim #)
a. OTHER INSURED'S POLICY OR GROUP NUMBER	
a. INSURED'S DATE OF BIRTH SEX	MM DD YY M ☐ F ☐
b. OTHER INSURED'S DATE OF BIRTH SEX	MM DD YY M ☐ F ☐
	b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)
b. EMPLOYER'S NAME OR SCHOOL NAME	XYZ Company
c. EMPLOYER'S NAME OR SCHOOL NAME	
	C. OTHER ACCIDENT? ☐ YES ☐ NO
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	☐ YES ☐ NO **If yes,** return to and complete item 9 a-d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE – I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE – I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	MM DD YY FROM MM DD YY TO
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	Xxxxxx Xxxxxx MD
17a. I.D. NUMBER OF REFERRING PHYSICIAN	0000000
18. HOSPITALIZATION DATES TO CURRENT SERVICES	MM DD YY FROM MM DD YY TO
19. RESERVED FOR LOCAL USE	
20. OUTSIDE LAB? $ CHARGES	☐ YES ☐ NO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)	1. XXX.XX 2. 3. 4.
22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.	
23. PRIOR AUTHORIZATION NUMBER	

24. A DATE(S) OF SERVICE MM DD YY MM DD YY	B PLACE OF SERVICE	C Type Of Service	D PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS / MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G Days Or Units	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
03 | 01 | 01 03 | 01 | 01	XX	3	XXXXX | XX	XXX.XX	XX | XX	1				

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
00-0000000 ☐ ☒	Optional	☐ YES ☐ NO	$ XX | XX	$	$

31. PHYSICIAN/SUPPLIER SIGNATURE INCLUDING DEGREES OR CREDENTIALS – (I certify that I understand L&I billing instructions, that information contained on this bill is consistent with those instructions and accurate to the best of my knowledge.)	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE PROVIDED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE AND PHONE #
SIGNED XXXXXXXX DATE XX/XX/XX		Xxxxxx Xxxxxx, PA 3112 Xxxxxx Lane Morton, WA 98519 (XXX) XXX-XXXX PIN # 0000000 | GRP # 0000000

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICES 8/88)
f245-127-000 (3/92)

L&I PROVIDER ACCOUNT # ⬆

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

L&I HEALTH INSURANCE CLAIM FORM

DEPARTMENT OF LABOR AND INDUSTRIES
CLAIMS SECTION
PO BOX 44269
OLYMPIA WA 98504-4269

PLEASE PRINT OR TYPE

Sample: Podiatric Physician

PICA

PICA

1.	L&I (ID) ☐	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 000-00-0000 (SSN)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, Jane	3. PATIENT'S BIRTH DATE SEX MM DD YY M ☐ F ☒	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street) 151 Oak Creek Lane	6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street)
CITY: Morton — STATE: WA	8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐	CITY — STATE
ZIP CODE: 98519 — TELEPHONE (Include Area Code): (360) 000-0000		ZIP CODE — TELEPHONE (Include Area Code): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO	11. INSURED'S POLICY GROUP OR FECA NUMBER Y 000000 (L&I Claim #)
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. INSURED'S DATE OF BIRTH SEX MM DD YY M ☐ F ☐
b. OTHER INSURED'S DATE OF BIRTH SEX MM DD YY M ☐ F ☐	b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State) |____|	b. EMPLOYER'S NAME OR SCHOOL NAME XYZ Company
c. EMPLOYER'S NAME OR SCHOOL NAME	C. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO **If yes,** return to and complete item 9 a-d.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE – I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE – I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____
14. DATE OF CURRENT: MM DD YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM | | TO MM DD YY | |
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE Xxxxxx Xxxxxx MD	17a. I.D. NUMBER OF REFERRING PHYSICIAN 0000000	18. HOSPITALIZATION DATES TO CURRENT SERVICES MM DD YY FROM | | TO MM DD YY | |
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES | |
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) ----------▼ 1. XXX.XX 3. |_____ . ____ 2. |_____ . ____ 4. |_____ . ____		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. | 23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE MM DD YY MM DD YY	B PLACE OF SERVICE	C Type Of Service	D PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G Days Or Units	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
03 | 01|01 03 | 01|01	XX	3	XXXXX | XX |	XXX.XX	XX | XX	1				
03 | 01|01 03 | 01|01	XX	3	XXXXX | XX |	XXX.XX	XX | XX	1				
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| | | |			| |		|					
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| | | |			| |		|					

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
00-0000000 ☐ ☒	Optional	☐ YES ☐ NO	$ XX | XX	$ |	$ |

31. PHYSICIAN/SUPPLIER SIGNATURE INCLUDING DEGREES OR CREDENTIALS – (I certify that I understand L&I billing instructions, that information contained on this bill is consistent with those instructions and accurate to the best of my knowledge.) SIGNED XXXXXXXX DATE XX/XX/XX	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE PROVIDED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE AND PHONE # Xxxxxx Xxxxxx, DPM 3112 Xxxxxx Lane Morton, WA 98519 (XXX) XXX-XXXX PIN # 0000000 | GRP # 0000000

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICES 8/88)
f245-127-000 (3/92)

L&I PROVIDER ACCOUNT # ⬆

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PLEASE PRINT OR TYPE

L&I HEALTH INSURANCE CLAIM FORM

DEPARTMENT OF LABOR AND INDUSTRIES
CLAIMS SECTION
PO BOX 44269
OLYMPIA WA 98504-4269

Sample: Psychologist

PICA | PICA

1. L&I (ID)		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 000-00-0000 (SSN)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, Jane	3. PATIENT'S BIRTH DATE SEX MM DD YY M ☐ F ☒	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street) 151 Oak Creek Lane	6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street)
CITY: Morton — STATE: WA	8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐	CITY — STATE
ZIP CODE: 98519 — TELEPHONE (Include Area Code): (360) 000-0000		ZIP CODE — TELEPHONE (Include Area Code): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) a. OTHER INSURED'S POLICY OR GROUP NUMBER b. OTHER INSURED'S DATE OF BIRTH SEX MM DD YY M ☐ F ☐ c. EMPLOYER'S NAME OR SCHOOL NAME d. INSURANCE PLAN NAME OR PROGRAM NAME	10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State) |____| C. OTHER ACCIDENT? ☐ YES ☐ NO 10d. RESERVED FOR LOCAL USE	11. INSURED'S POLICY GROUP OR FECA NUMBER Y 000000 (L&I Claim #) a. INSURED'S DATE OF BIRTH SEX MM DD YY M ☐ F ☐ b. EMPLOYER'S NAME OR SCHOOL NAME XYZ Company c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO **If yes,** return to and complete item 9 a-d.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE – I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE – I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM | | TO MM DD YY | |
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE Xxxxxx Xxxxxx MD	17a. I.D. NUMBER OF REFERRING PHYSICIAN 0000000	18. HOSPITALIZATION DATES TO CURRENT SERVICES MM DD YY FROM | | TO MM DD YY | |
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES | |
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) ---------- 1. XXX.XX 3. |_____ . ____ 2. |_____ . ____ 4. |_____ . ____		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. | 23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE MM DD YY MM DD YY	B PLACE OF SERVICE	C Type Of Service	D PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G Days Or Units	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
03 | 01|01 — 03 | 01|01	XX	3	XXXXX | XX |	XXX.XX	XX | XX	1				
| | — | |			| |		|					
| | — | |			| |		|					
| | — | |			| |		|					
| | — | |			| |		|					
| | — | |			| |		|					

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
00-0000000 ☐ ☒	Optional	☐ YES ☐ NO	$ XX | XX	$ |	$ |

31. PHYSICIAN/SUPPLIER SIGNATURE INCLUDING DEGREES OR CREDENTIALS – (I certify that I understand L&I billing instructions, that information contained on this bill is consistent with those instructions and accurate to the best of my knowledge.)	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE PROVIDED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE AND PHONE #
SIGNED XXXXXXXX DATE XX/XX/XX		Xxxxxx Xxxxxx, PhD 3112 Xxxxxx Lane Morton, WA 98519 (XXX) XXX-XXXX PIN # 0000000 | GRP # 0000000

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICES 8/88)
f245-127-000 (3/92)

L&I PROVIDER ACCOUNT # ⬆

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PLEASE PRINT OR TYPE

L&I HEALTH INSURANCE CLAIM FORM

DEPARTMENT OF LABOR AND INDUSTRIES
CLAIMS SECTION
PO BOX 44269
OLYMPIA WA 98504-4269

Sample: Radiology

PICA | PICA

1. L&I (ID)		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 000-00-0000 (SSN)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, Jane	3. PATIENT'S BIRTH DATE SEX MM DD YY M ☐ F ☒	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street) 151 Oak Creek Lane	6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street)
CITY: Morton — STATE: WA	8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐	CITY — STATE
ZIP CODE: 98519 — TELEPHONE (Include Area Code): (360) 000-0000		ZIP CODE — TELEPHONE (Include Area Code): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO	11. INSURED'S POLICY GROUP OR FECA NUMBER Y 000000 (L&I Claim #)
a. OTHER INSURED'S POLICY OR GROUP NUMBER	b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State) |____|	a. INSURED'S DATE OF BIRTH SEX MM DD YY M ☐ F ☐
b. OTHER INSURED'S DATE OF BIRTH SEX MM DD YY M ☐ F ☐	C. OTHER ACCIDENT? ☐ YES ☐ NO	b. EMPLOYER'S NAME OR SCHOOL NAME XYZ Company
c. EMPLOYER'S NAME OR SCHOOL NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO **If yes,** return to and complete item 9 a-d.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE – I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE – I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM | | TO MM DD YY | |
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE Xxxxxx Xxxxxx MD	17a. I.D. NUMBER OF REFERRING PHYSICIAN 0000000	18. HOSPITALIZATION DATES TO CURRENT SERVICES MM DD YY FROM | | TO MM DD YY | |
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES | |
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) ----------↓ 1. XXX.XX 3. |_____ . ____ 2. |_____ . ____ 4. |_____ . ____		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. | 23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE MM DD YY MM DD YY	B PLACE OF SERVICE	C Type Of Service	D PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G Days Or Units	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
03 | 01|01 03 | 01|01	XX	3	XXXXX | XX |	XXX.XX	XX | XX	1				
03 | 01|01 03 | 01|01	XX	3	XXXXX | XX |	XXX.XX	XX | XX	1				
| | | |			| |		|					
| | | |			| |		|					
| | | |			| |		|					
| | | |			| |		|					

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
00-0000000 ☐ ☒	Optional	☐ YES ☐ NO	$ XX | XX	$ |	$ |

31. PHYSICIAN/SUPPLIER SIGNATURE INCLUDING DEGREES OR CREDENTIALS – (I certify that I understand L&I billing instructions, that information contained on this bill is consistent with those instructions and accurate to the best of my knowledge.)	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE PROVIDED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE AND PHONE #
SIGNED XXXXXXXX DATE XX/XX/XX		Jones Radiology Inc 3112 Xxxxxx Lane Morton, WA 98519 (XXX) XXX-XXXX PIN # 0000000 | GRP # 0000000

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICES 8/88)
f245-127-000 (3/92)

L&I PROVIDER ACCOUNT # ⬆

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

REBILLS

REBILLS should be submitted when:

Your TOTAL BILL has been denied.
Your bill was sent in over 60 days ago and is not yet showing up on your Remittance Advice

You are **required** to REBILL: (WAC 296-20-125)

- For TOTAL BILLS denied because the claim was closed and the claim has now been reopened
- For TOTAL BILLS denied because the claim was first rejected and the claim has now been allowed.
- For TOTAL BILLS denied because a diagnosis was at first not allowed and the diagnosis has now been allowed

Rebills must be received at the department **within one year of the date the final order was issued** which reopened or allowed the claim or diagnosis.

A Rebill should be identical to the original bill: same charges, codes and dates of service.
Rebills should be submitted on new **ORIGINAL** bill forms. We cannot process photocopies or facsimiles.

ADJUSTMENTS

A "Providers Request for Adjustment " form (F245-183-000) should be submitted to correct an incorrect field on a bill that has **already processed and partially paid**.

Enter the workers name (field 1), their claim number as it appears on your REMITTANCE ADVICE (field 2), the correct claim number if applicable (field 3), the providers name and address (field 4), the ICN (internal control number) of the bill (field 5) as it appears on your REMITTANCE ADVICE (see example headings below for location of the ICN as it appears on your REMITTANCE ADVICE), the performing providers L&I provider number (field 6) and L&I payee number (field 7), if applicable.

					Service Dates				Billed
Claim #	Name	I	Patient Acct#	ICN	From	To	Unit	Procedure	Charge
P000000	XXXXXXX	X	XXXXXXXXXX	**00101825045000200**	121300	12/17/01	1	XXXXX	XX.XX

In the body of the form (field 8) correct only those line item fields that have been paid or denied incorrectly due to incorrect information. Enter only the corrected information (as it should have appeared on the original bill) in the line item fields corresponding to the line item fields on your bill as it appears on your REMITTANCE ADVICE.

EXAMPLE:

You billed one unit of service on line one but four units were actually completed and should be payable. You've only been paid for one unit. Everything else on the bill is correct. In field 8, on line one of the adjustment form, enter '4' in the 'unit' field. After the adjustment processes you will receive payment for the three units previously unpaid.

Please attach to the adjustment form a copy of your ORIGINAL BILL and a copy of the page of your REMITTANCE ADVICE where your paid bill appears.

Request for Reconsideration on **adjustments initiated by the department**

Per legal notice on your REMITTANCE ADVICE, a request for reconsideration of a payment must be made in writing within 20 days of receipt of notice of the adjustment/deduction.

The basis for the request for reconsideration must be other than an objection to the payment amount established by the departments' fee schedule.

All supporting documentation relevant to the reconsideration request must be submitted with the request.

Note:
DO NOT SUBMIT an adjustment or a rebill for a bill that is reported "in process" on your Remittance Advice. If the bill remains in the "in process" status for **over 60 days**, call our Provider Hotline at 1-800-848-0811. For bills "in process" **under 60 days** you may access the Claim Information Line by calling 1-800-831-5227. Once you access the 'in process' bill information, you may choose the 'zero' option to be connected to the bill payment section.

Adjustments will appear as the last item on the Remittance Advice as follows:

(See sample RA on page 37)

Your original bill will be reprinted, appearing as a credit for the amount previously paid, (e.g., $100.00 - CRE).

Your adjustment will usually appear immediately following the credit of your bill.

If an additional payment is allowed, the total amount allowed for the bill will be reported (e.g., $125.00). The difference between original and adjusted payment will be paid in the warrant (e.g., $25.00).

If no additional fee is allowable, the amount of the adjustment will be equal to the credit of the previous payment (e.g., $100.00).

If the original payment is being recouped, the total or partial amount allowed for the bill will be reported (e.g., $0.00). The "adjusted payment" will recoup the original amount of the bill and report the difference as a credit (monies owed back to the department).

NO STAPLES IN
BAR CODE AREA

[redacted]

Department of Labor and Industries
Claims Section
PO Box 44267
Olympia WA 98504-4267

PROVIDER'S REQUEST FOR ADJUSTMENT

CHECK ONE → TOTAL OVERPAYMENT
PARTIAL OVERPAYMENT
UNDERPAYMENT

DO NOT WRITE IN SPACE

Please type or print in Dark ink

ENTER DATA FROM ORIGINAL REMMITTANCE ADVICE	INSTRUCTIONS ARE ENCLOSED	
1) WORKERS NAME (Last, First, Middle)	2) CLAIM NUMBER ON REMIT ADVICE	3) CORRECT CLAIM NUMBER
4) PROVIDER NAME AND ADDRESS	5) ICN NUMBER ON REMITTANCE ADVICE	
	6) PROVIDER NUMBER	
	7) PAYEE NUMBER	

COMPLETE ONLY THOSE LINE ITEMS PAID/DENIED IN ERROR - ENTER ONLY CORRECTED INFORMATION

8) Line Item No.	a) From/to Date of Service pr overed Dates	b) POS	c) TOS	d) Procedure Code/ Revenue Code/NDC	e) CODE MOD	f) ICD-9-CM Diagnosis/ Side of Body	g) Tooth No.	h) Charge	i) Days/ Units/ Quantity	j) Days Supply	k) Description
01											
02											
03											
04											
05											
06											
07											
08											
09											
10											
11											
12											
13											
14											

9. OTHER REMARKS/JUSTIFICATIONS/SPECIAL CIRCUMSTANCES - ATTACH REQUIRED REPORTS - EXPLAIN FULLY

DATE	SIGNATURE OF PERSON COMPLETING FORM	PHONE NUMBER ( )

F245-183-000 provider's request for adjustment 2/00

ADJUSTMENT REQUEST FORM

THE ADJUSTMENT REQUEST FORM MAY BE USED IN THE FOLLOWING INSTANCES:

TOTAL OVERPAYMENT ---- Entire bill was paid in error. You may either submit an Adjustment Request Form and we will process a credit to recover our payment; OR you may issue a refund check directly to the Department. If a refund is submitted, you must attach a copy of the remittance advice indicating the ICN overpaid. Submit refunds to:

Cashiers Office
Department of Labor and Industries
PO Box 44835
Olympia WA 98504-4835

PARTIAL OVERPAYMENT --- A portion of the bill was overpaid. Complete Adjustment Request Form with correct information, including date of service, for the procedures/items paid incorrectly.

UNDERPAYMENT ---------- If a bill has been underpaid in error, the Adjustment Request Form must be completed with all pertinent information including date of service. Corrections or justification and/or reports must be included.

This form may **NOT** be used for:
Bills returned to you by the Department **OR** totally denied bill. New bill must be submitted.

INSTRUCTIONS FOR COMPLETING ADJUSTMENT REQUEST

Submit only one form for each ICN (Internal Control Number).
Attach a copy of remittance advice and original bill.

1. **WORKER'S NAME:** Clearly print injured worker's full name.
2. **CLAIM NUMBER ON REMITTANCE ADVICE:** Enter the 7-digit number found in the Claim Number column on the remittance advice.
3. **CORRECT CLAIM NUMBER:** Claim number these services should be paid under.
4. **PROVIDER NAME AND ADDRESS:** Enter the name and address of the provider providing the service. Include telephone number.
5. **ICN NUMBER:** Enter the 17-digit number found in the ICN column to identify the bill submitted.
6. **PROVIDER NUMBER:** Enter the Labor and Industries provider account number for the provider of service as it appears on the remittance advice.
7. **PAYEE NUMBER:** Enter the Labor and Industries payee provider account number if payee was **different** than the provider of service.
8. **SERVICE ITEMIZATION:** Complete only for those line items to be corrected. Enter corrected information on line item number corresponding to line item number on original bill.
    a. **From/to Date of Service or Covered Dates:** Date of Service, from and to date if date span previously billed. Admit and discharge date for hospital bill.
    b. **Place of Service:** (POS) Two digit code identifying the place of service was performed.
    c. **Type of Service:** (TOS) One digit code identifying the general type of service performed.
    d. **Procedure Code/Revenue Code/NDC:** Identify correct procedure, hospital service or national drug code.
    e. **Code Mod:** Modifier used to identify special circumstances for a service or procedure.
    f. **ICD-9-CM Diagnosis/Side of Body:** ICD-9-CM diagnosis code for condition treated. Designate left or right side of body where applicable.
    g. **Tooth Number:** For dental services only. Enter the two digit identification number of the specific tooth number treated (e.g., 08).
    h. **Charge:** Total of charges for services provided this line.
    i. **Days/Units/Quantity:** Total days stay for hospital accommodation codes, unit of service for procedure (time units, hours, miles, etc.), number of items (tablets, milliliters, etc.).
    j. **Days Supply:** Total number of days a prescription is intended to cover.
    k. **Description:** Describe procedure or service.
9. **OTHER REMARKS/JUSTIFICATION/SPECIAL CIRCUMSTANCES:** Enter sufficient justification for adjustment. Indicate the service line and date of service. Attach required reports.

SAMPLE PAGE
BLMC8000-R001
AS OF 04/27/2002

DEPARTMENT OF LABOR AND INDUSTRIES
OLYMPIA, WASH 98504

007589

REMITTANCE ADVICE

INSTRUCTIONS:
1. REFER TO LAST PAGE FOR LEGAL NOTICES
2. FOR HELP WITH SUSPENDED BILLS: CALL 1-800-831-5227
3. FOR HELP WITH FINALIZED BILLS: CALL 1-800-848-0811

PAYEE PROVIDER NUMBER **0000000** REMIT ADVICE # **XXXXXX** WARRANT REGISTER NUMBER **60048** DATE **04/30/2002** PAGE **X**

CLAIM NUMBER	NAME	I	PATIENT ACCT/RX NUMBER	ICN	SERVICE FROM	DATES TO	UNIT OF SVC	PROCEDURE REVENUE NDC	BILLED CHARGES	ALLOWED	TAX OR NON-COVD CHARGES	PAYABLE	EOB CODES
PAID BILLS - PRACTITIONER BILL													
P000000	XXXXXXX	X	XXXXXXXXXX	00211225035001100	XXXXXX	XXXXXX	1	XXXXX	XX.XX	XX.XX	0.00	XX.XX	
					XXXXXX	XXXXXX	1	XXXXX	XX.XX	XX.XX	0.00	XX.XX	
					XXXXXX	XXXXXX	1	XXXXX	XX.XX	XX.XX	0.00	XX.XX	
					XXXXXX	XXXXXX	1	XXXXX	XX.XX	XX.XX	0.00	XX.XX	
					BILL TOTAL***				XX.XX	XX.XX	0.00	XX.XX	
***PAID BILLS TOTAL – PRACTITIONER BILLS					**NUMBER OF BILLS			1	XX.XX	XX.XX	0.00	XX.XX	
BILLS-IN-PROCESS - PRACTITIONER BILL													
X000000	XXXXXXX	X	XXXXXXXXXX	00211225035001200	XXXXXX	XXXXXX	1	XXXXX	X.XX	X.XX	0.00	X.XX	
					XXXXXX	XXXXXX	2	XXXXX	XX.XX	XX.XX	0.00	XX.XX	
					BILL TOTAL **				XX.XX	XX.XX	0.00	XX.XX	559
***BILLS PENDING TOTAL – PRACTITIONER BILLS					***NUMBER OF BILLS-			1	XX.XX	0.00	0.00	0.00	
DENIED BILLS – PRACTITIONER BILL													
X000000	**XXXXXXX**	**X**	**321**	**00211125004006000**	XXXXXX	XXXXXX	**1**	**##M##**	**XX.XX**	**0.00**	**0.00**	**0.00**	**045**
					XXXXXX	XXXXXX	**1**	**###A#**	**XXX.XX**	**0.00**	**0.00**	**0.00**	**045**
					XXXXXX	XXXXXX	**1**	**M####**	**XXX.XX**	**XXX.XX**	**0.00**	**XXX.XX**	
					*****BILL TOTAL*******				**XXX.XX**	**XXX.XX**	**0.00**	**XXX.XX**	
*****DENIED BILL TOTAL – PRACTITIONER BILLS**					*****NUMBER OF BILLS-**			**1**	**XXX.XX**	**XXX.XX**	**0.00**	**XXX.XX**	
ADJUSTMENT – BILLS - PRACTITIONER BILL													
X000000	**XXXXXXX**	**X**	**321**	**00211325007101500**	XXXXXX	XXXXXX	**1**	**##M##**	**XX.XX-**	**0.00-**	**0.00**	**0.00-**	
					XXXXXX	XXXXXX	**1**	**###A#**	**XXX.XX-**	**0.00-**	**0.00**	**0.00-**	
					XXXXXX	XXXXXX	**1**	**M####**	**XXX.XX-**	**XXX.XX-**	**0.00**	**XXX.XX-**	
					*****BILL TOTAL*******				**XXX.XX-**	**XXX.XX-**	**0.00**	**XXX.XX-**	**CRE**
X000000	**XXXXXXX**	**X**	**321**	**00211325007201500**	XXXXXX	XXXXXX	**1**	**M####**	**XX.XX**	**XX.XX**	**0.00**	**XX.XX**	
					XXXXXX	XXXXXX	**1**	**A####**	**XXX.XX**	**XXX.XX**	**0.00**	**XXX.XX**	
					XXXXXX	XXXXXX	**1**	**M####**	**XXX.XX**	**XXX.XX**	**0.00**	**XXX.XX**	
					*****BILL TOTAL*******				**XXX.XX**	**XXX.XX**	**0.00**	**XXX.XX**	
****ADJUSTMENT TOTALS – PRACTITIONER BILL**					****NUMBER OF BILLS -**			**2**	**XXX.XX**	**XXX.XX**	**0.00**	**XXX.XX**	

EOB 045 – Denied. Type Service/Procedure Code is invalid. Refer to current Fee Schedule for valid code.

TYPE OF SERVICE CODES:

C	Chiropractic Services	P	Physical Therapy
D	Drugless Therapeutics	V	Vocational Services
I	Inpatient	3	Medical Services
N	Nurse Practitioner Services	4	Dental
O	Outpatient	9	AncillaryServices (attendant,equipment, glasses)

PLACE OF SERVICE CODES:

03. School
04. Homeless Shelter
05. Indian Health Service Free-standing Facility
06. Indian Health Service Provider-based Facility
07. Tribal 638 Free-standing Facility
08. Tribal 638 Provider-based Facility
11. Office
12. Patient's Home
15. Mobile Unit
21. Inpatient Hospital
22. Outpatient Hospital
23. Emergency Rm – Hospital
24. Ambulatory Surgical Ctr
25. Birthing Ctr
26. Military Trmt Facility
31. Skilled Nursing Facility
32. Nursing Facility
33. Custodial Care Facility
34. Hospice
41. Ambulance – Land
42. Ambulance – Air or Water
50. Federally Qualified Hlth Ctr
51. Inpatient Psychiatric Facility
52. Psychiatric Facility Partial Hospitalization
53. Community Mental Health Ctr
54. Intermediate Care Facility/Mentally Retarded
55. Residential Substance Abuse Trtmt Facility
56. Psychiatric Residential Trmt Ctr
60. Mass Immunization Ctr
61. Comprehensive Inpatient Rehabilitation Facility
62. Comprehensive Outpatient Rehab Facility
65. End Stage Renal Disease Trmt Facility
71. State or Local Public Health Clinic
72. Rural Hlth Clinic
81. Independent Laboratory
99. Other Unlisted Facility

Directory:

Field Service Offices

Aberdeen:
415 West Wishkah, Suite 1B
Aberdeen WA 98520-0013
(360) 533-8200

Bellevue:
616 120th Avenue NE, Suite C201
Bellevue WA 98005-3037
(425) 990-1400

Bellingham:
1720 Ellis Street, Suite 200
Bellingham WA 98225-4600
(360) 647-7300

Bremerton:
500 Pacific Avenue, Suite 400
Bremerton WA 98337-1904
(360) 415-4000

Colville:
298 South Main, Suite 203
Colville WA 99114-2416
(509) 684-7417
1-800-509-9174

East Wenatchee:
519 Grant Road
East Wenatchee WA 98802-5459
(509) 886-6500
1-800-292-5920

Everett:
729 100th St SE
Everett WA 98208-3727
(425) 290-1300

Goldendale:
777 E Broadway, Suite E
Goldendale WA 98620-9286
(509) 773-3723

Kennewick:
4310 W 24th Ave
Kennewick WA 99338
NEW (509) 735-0100
ADDRES 1-800-547-9411

Longview:
900 Ocean Beach Hwy
Longview WA 98632-4013
(360) 575-6900

Moses Lake:
3001 W Broadway Ave
Moses Lake WA 98837-2907
(509) 764-6900

Mount Vernon:
525 E College Way, Suite H
Mount Vernon WA 98273-5500
(360) 416-3000

Okanogan:
1234 2nd Avenue S
Okanogan WA 98840-0632
(509) 826-7345

Port Angeles:
1605 East Front Street, Suite C
Port Angeles WA 98362-4628
(360) 417-2700

Pullman:
1250 Bishop Blvd SE, Suite G
PO Box 847
Pullman WA 99163-0847
(509) 334-5296
1-800-509-0025

Seattle:
300 W Harrison Street
Seattle WA 98119-4081
(206) 281-5400

Spokane:
901 N Monroe Street, Suite 100
Spokane WA 99201-2149
(509) 324-2600
1-800-509-8847

Tacoma:
NEW ADDRESS
950 Broadway Suite 200
Tacoma WA 98402-4453
(253) 596-3800

Tukwila:
12806 Gateway Drive
PO Box 69050
NEW PH # Seattle WA 98168-1050
(206) 835-1000

Tumwater:
PO Box 44851
7273 Linderson Way SW
Olympia WA 98501-5414
(360) 902-5799

Vancouver:
312 SE Stonemill Dr, Suite 120
Vancouver WA 98684-3508
(360) 896-2300

Walla Walla:
1815 Portland Avenue, Suite 2
Walla Walla WA 99362-2246
(509) 527-4437

Yakima:
15 W Yakima Avenue, Suite 100
Yakima WA 98902-3401
(509) 454-3700
1-800-354-5423

- **indicates Regional Office**
- **(Revised 5/7/2002)**